

MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES

June 4, 2004
1:00 PM - 2:30 PM
via conference call

OFFICIAL

Commissioners in attendance: Gregg Laiben, Thomas Cartmell, Alan Morris, Kathryn Nelson, William Schoenhard, Barry Spoon, James Utley, Stephen Smith, Tina Steinman, Lois Kollmeyer, Kevin Kinkade, Kenneth Vuylsteke, Deborah Jantsch (Any person on the call for some period of time was considered in attendance. Not all of the above were able to stay on the call for the entire time.)

Called to order at 1:00 PM.

Housekeeping items:

- Minutes from the previous meeting were not reviewed.
- All Commissioners should have received via email the most updated main and sub-recommendations, with all comments that Commissioners sent to Linda Bohrer noted.
 - Dr. Laiben noted that some didn't have any commentary. The understanding is that the Commission has agreed to those, and they don't need to be discussed further.
 - Each recommendation and sub-recommendation will be read, and any alternative drafts will be read. Dr. Laiben called for the Commissioners to vote on the options presented, without any further editing or changes.

Dr. Laiben asked to go through the main recommendations first, in order, before voting on any sub-recommendations.

I. Discussion of recommendations

Recommendation #1:

Educate all Missouri healthcare organizations and professionals regarding patient safety and encourage them to adopt protocols and processes for improving the safety of patients.

Alternative: (submitted by Director Lakin)

All Missouri healthcare organizations and professionals should be educated regarding patient safety and encouraged to adopt protocols and processes for improving the safety of patients.

Linda Bohrer told the Commission she had asked various people in MDI who were uninvolved with the Commission to read the recommendations. She noted that, because this recommendation begins with "educate", readers otherwise unfamiliar with the Commission's work don't grasp that this recommendation is about minimum expectations and actions that healthcare organizations should take.

Dr. Laiben felt that the alternative language drafted by Scott Lakin seemed to be the best statement. There was no disagreement. It was agreed the recommendation would read: **"All Missouri healthcare organizations and professionals should be educated regarding patient safety and encouraged to adopt protocols and processes for improving the safety of patients."**

Recommendation #2:

Establish a "Patient Safety Support Center" as the leadership vehicle for future unified coordinated patient safety improvements. The "Support Center" should be a private organization, partnering with appropriate public agencies.

Alternative: (submitted by Director Lakin)

A "Patient Safety Support Center" should be established as a leadership vehicle for future unified and coordinated patient safety improvements and to be a continued resource for healthcare providers, organizations and consumers as they strive to increase patient safety.

Dr. Laiben noted again that Director Lakin's alternative language was preferable, with some minor changes. There was no disagreement. It was agreed the recommendation would read: **"Establish a patient safety support center as a leadership vehicle for future unified and coordinated patient safety improvement and to be a continued resource for healthcare providers, organizations and consumers as they strive to increase patient safety."**

Recommendation #3:

Provide for better statutory protection of quality assurance, improvement and patient safety activities, which would encourage healthcare organizations and professionals to voluntarily report information and participate in peer review/quality improvement activities.

Alternative: (submitted by Director Lakin)

Provide for statutory protection of quality assurance, improvement and patient safety activities, to encourage healthcare organizations and professionals to voluntarily report information and participate in peer review/quality improvement activities.

Alternative: (submitted by Dr. Smith)

Promulgate enhanced statutory protection of quality improvement activities, encouraging healthcare organizations and professionals to participate in peer

review/quality improvement activities and voluntarily report information that will lead to increased patient safety.

Alternative: (submitted by Dr. Utley)

Provide for better statutory protection for the transmission and analysis of patient safety related information such that healthcare organizations and professionals will voluntarily develop and anticipate in internal review procedures intended to improve the safety of patients.

Dr. Laiben stated that he didn't think "better" statutory protection was clear, unless additional detail was provided. Dr. Morris agreed, and stated he felt the same way about "more" statutory protection. He felt that these statements would make readers feel something was missing from the statutes. Dr. Utley suggested "more comprehensive". Dr. Laiben acknowledged this was the right idea, but asked to stick to the alternatives presented, and select one.

Dr. Laiben asked if any Commissioner disagreed with using Director Lakin's version. There was no disagreement. It was agreed the recommendation would read: **“Provide for statutory protection of quality assurance, improvement and patient safety activities, to encourage healthcare organizations and professionals to voluntarily report information and participate in peer review/quality improvement activities.”**

Recommendation #4:

Improve education opportunities for current and future healthcare professionals on patient safety concepts.

Alternative: (submitted by Dr. Smith)

Improve education opportunities as it relates to patient safety concepts for healthcare professionals.

Alternative: (submitted by Dr. Smith)

Establish a curriculum of key patient safety concepts for the continuing education of healthcare professionals as well as those in training.

Alternative: (submitted by Sue Kendig)

Establish a curriculum of key patient safety concepts for the primary training and continuing education of healthcare professionals.

Alternative: (submitted by Dr. Utley)

Improve patient safety related education opportunities for current and future healthcare professionals.

Dr. Laiben stated he preferred Sue Kendig's alternative, because it was clearly stated and included both primary and continuing education. There was no disagreement. It was agreed the recommendation would read: **“Establish a curriculum of key patient safety concepts for the primary training and continuing education of healthcare professionals.”**

Recommendation #5:

Convene legislators, elected officials, professional healthcare associations, and regulatory agencies to evaluate and address more effective regulation of licensees in the interest of patient safety.

Alternative: (submitted by Director Lakin)

Work with legislators, elected officials, professional healthcare associations, and regulatory agencies to evaluate and address more effective regulation of licensees in the interest of patient safety.

Dr. Laiben stated he didn't feel "convene" was the right word to use. He noted that Dr. Smith had suggested dropping this recommendation, but Sue Kendig and Nancy Kimmel disagreed. Dr. Morris stated his support for keeping the recommendation. Dr. Spoon also supported keeping it, and stated he preferred Director's Lakin's language. Dr. Morris suggested deleting "more", for the same reasons stated earlier. Dr. Laiben supported this change, on the grounds of parallel construction. No one disagreed. It was agreed the recommendation would read: **"Work with legislators, elected officials, professional healthcare associations, and regulatory agencies to evaluate and address effective regulation of licensees in the interest of patient safety."**

Recommendation #6:

Develop strategies to enhance communication between patients and healthcare professionals, improve patient understanding of health conditions and medical procedures, and increase the patient's involvement in their healthcare.

Alternative: (Submitted by Dr. Morris)

Empower patient involvement in their own healthcare, their diagnoses and proposed medical procedures through enhanced communication with healthcare professionals.

Alternative: (Submitted by Dr. Smith)

Heighten patient involvement in healthcare decisions through a strategy of patient education regarding their health condition and associated medical procedures as well as enhanced communication with healthcare professionals.

Dr. Laiben stated he supported alternative language submitted by Dr. Morris. No one disagreed. It was agreed the recommendation would read: **"Empower patient involvement in their own healthcare, their diagnoses and proposed medical procedures through enhanced communication with healthcare professionals."**

Dr. Morris asked the Commission if this recommendation was important enough to place it earlier in the list. Dr. Laiben felt Dr. Morris's suggestion was commendable, and suggested making it #2. Linda noted that people within MDI had expressed a similar suggestion. **The Commission agreed to make this recommendation #2.**

Recommendation #7:

Provide healthcare organizations and professionals with financial and other incentives to participate in proven patient safety activities.

Linda Bohrer reported that the legislative liaison at MDI suggested removing "financial", and allowing the recommendation to apply to any type of incentive. Dr. Spoon asked for an example of a non-financial incentive. Linda Bohrer responded that the recognition and prestigious awards for patient safety would be non-financial incentives. There was no disagreement on the suggested change. It was agreed this recommendation will read: **"Provide healthcare organizations and professionals with incentives to participate in proven patient safety activities."**

Recommendation #1a:

Creating a culture of safety by focusing on system improvements and process changes to reduce patient harm.

Alternate language: (submitted by Dr. Smith)

Create a culture of safety by adopting a system-oriented approach focusing on system improvements and process changes to reduce patient harm.

Dr. Laiben felt Dr. Smith's suggestion was good, but asked to change it slightly. There was no disagreement. It was agreed the recommendation would read: **"Create a culture of safety, focusing on a system oriented approach to reduce patient harm."**

Recommendation #1b:

Establishment of internal patient safety reporting systems for adverse events and near-misses.

Additional recommendation: (submitted by Dr. Utley)

Promote the use of the tools of safety (e.g., root cause analysis, etc.)

Dr. Laiben suggested a grammatical change. There was no disagreement. It was agreed the recommendation would read: **"Establish internal patient safety reporting systems for adverse events and near-misses."**

Recommendation #1c:

Develop an awareness of best practices.

Alternate language: (submitted by Director Lakin)

Developing an awareness and implementation of best practices.

Alternate language: (submitted by Dr. Smith)

Incorporate best practices as recommended by JACHO, AHRQ, and LeapFrog.

Alternate language: (submitted by Dr. Utley)

Promote the awareness and appropriate implementation of those best practices that are acknowledged to result in greater patient safety.

Dr. Laiben suggested combining some of the alternatives. There was no disagreement. It was agreed the recommendation would read: **"Develop awareness and promote implementation of best practices."**

Dr. Utley urged the Commission to define "best practices". Linda Bohrer noted that this term appears in the draft Glossary, but no definition has been drafted yet. Dr. Laiben agreed and asked Linda to **assure that "best practices" is defined in the Glossary in terms of patient safety.**

Recommendation 1d:

Establishment of guidelines to disclose adverse events and outcomes to patients, their families or guardians.

Alternate language: (submitted by Dr. Utley)

Establish guidelines for the disclosure of adverse events and outcomes to patients and their families or guardians

Dr. Laiben preferred Dr. Utley's alternative, except for the last part. He suggested omitting reference to parents or legal guardians on the grounds that the recommendation was overly complex. Dr. Spoon countered that Children's Mercy had testified on the importance of disclosure to adults when treating minors. He felt omitting the reference to parents or guardians would make the recommendation too restrictive. Linda suggested **expanding on the issue of parents and guardians in the background text**, so the recommendation could stay a simple statement. The Commissioners generally supported this idea. It was agreed the recommendation would read: **"Establish guidelines for the disclosure of adverse events and outcomes to patients."**

Recommendation #1e:

Provide an identifiable resource for patient advocacy and counseling to anyone physically or emotionally impacted by an adverse event.

Alternate language: (submitted by Dr. Utley)

Provide an identifiable patient advocate and a counseling resource for any patient impacted by and adverse event or outcome.

Alternate language: (submitted by Dr. Smith)

Designate a patient advocate and provide counseling to those physically or emotionally impacted by an adverse event or outcome.

Dr. Laiben preferred Dr. Utley's alternative, with some grammatical changes. There was no disagreement. It was agreed the recommendation would read: **Identify a patient advocate and counseling resource for any patient impacted by an adverse event or outcome.**

Recommendation #1f:

Designate a "patient safety officer" appropriate to each healthcare setting (institution).

Linda Bohrer clarified that someone had suggested "institution" instead of "setting". Dr. Laiben said he preferred "setting". He asked if there was any disagreement to using the original language. There was none. It was agreed the

recommendation would read: **“Designate a “patient safety officer” appropriate to each healthcare setting.”**

Recommendation #1g:

Adopt common terminology to be used in patient safety and adverse event prevention.

Alternate language: (submitted by Dr. Utley)

Adopt a common patient terminology.

Dr. Laiben felt that Dr. Utley's alternative language was very well stated. There was no disagreement. It was agreed the recommendation would read: **“Adopt a common patient safety terminology.”**

Recommendation #1h:

Protect any healthcare professional or employee who in good faith reports conditions or events that jeopardize patient safety.

Alternative language: (submitted by Dr. Smith)

Promulgate legislation to prohibit any healthcare organization in Missouri from taking adverse employment or credentialing action against an individual healthcare professional based on that individual's participation in the development, collection, reporting or storage of patient safety data.

Dr. Laiben stated he preferred the original language on the grounds that it was direct and concise. The detail provided by Dr. Smith can be used in the background text. There was no disagreement. It was agreed this recommendation would remain as originally stated.

Recommendation #1i:

Recognition of the need for ongoing evaluation of technological advances that can enhance patient safety.

Alternate language: (submitted by Dr. Utley)

Establish an ongoing procedure for monitoring and promoting technological advances that enhance patient safety.

Dr. Laiben stated he preferred the original language, but with some changes. Several other Commissioners also suggested changes. It was agreed that this recommendation would state: **“Promote evaluation and implementation of technological advances that can enhance patient safety.”**

Recommendation #1j:

Establish an ongoing review of adequate availability of healthcare professionals and staff training, thereby recognizing the role of these components in promoting patient safety.

Alternate language: (submitted by Director Lakin)

Establish an ongoing review of adequate availability of healthcare professionals and staff training.

Dr. Laiben stated he preferred Director Lakin's alternative. There was no disagreement. It was agreed the recommendation would read: **"Establish an ongoing review of adequate availability of healthcare professionals and staff training."**

Recommendation #1k:

Promote use of the tools of safety such as root cause analysis, healthcare failure mode effects analysis, human factors engineering and interdisciplinary team training.

Dr. Utley had suggested several changes, including moving this recommendation up in the list of sub-recommendations. Dr. Laiben asked Dr. Utley to clarify his intent. Dr. Utley explained that a simple statement would be sufficient, and the background text or Glossary could provide specific examples. He also felt this recommendation followed logically from the recommendation to promote a culture of patient safety. It was agreed use a simple statement, **define the term "tools of patient safety" in the glossary, and move this recommendation up to the #1c position.** The recommendation will read: **"Promote the use of the tools of patient safety."**

Recommendation #2a:

Become a clearinghouse for collection, analysis, and dissemination of information and tools related to the issue of patient safety.

Dr. Laiben asked the Commission to consider some changes. There was no disagreement. It was agreed the recommendation will read: **"Provide a clearinghouse for collection, analysis and dissemination of patient safety information, tools and best practices."**

Recommendation #2b:

Collect information on best practices that eliminate conditions contributing to adverse events and disseminate those findings broadly to healthcare organizations, healthcare professionals and consumers.

Alternate language: (submitted by Dr. Utley)

Collect information on those best practices that improve patient safety and disseminate it broadly to healthcare organizations and professionals and consumers.

Dr. Laiben noted that, given the revisions to #2a, #2b is unnecessary and suggested deleting it. There was no disagreement. **It was agreed this sub-recommendation would be deleted.**

Recommendation #2c:

Provide training and support for healthcare professionals and organizations to implement patient support groups and advocacy programs.

Alternate language: (submitted by Director Lakin)

Implement patient support groups and advocacy programs.

Alternate language: (submitted by Dr. Utley)

Provide training and support for healthcare professionals and organizations regarding the implementation of patient support groups and advocacy programs.

Dr. Laiben stated he preferred Director Lakin's alternative. There was no disagreement. It was agreed this recommendation will read: **“Implement patient support groups and advocacy programs.”**

Recommendation #2d:

Provide technical assistance to health care organizations and professionals on root cause analysis, healthcare failure mode effects analysis, human factors engineering, interdisciplinary team training and other safety tools.

Alternate language: (submitted by Dr. Utley)

Provide technical assistance to health care organizations and professionals on the use of the tools of safety. (Define tools in glossary and include some of the listing of tools there.)

Dr. Laiben stated he preferred Dr. Utley's alternative. However, he suggested **"use of the tools of patient safety"**, which will be defined as already discussed. There was no disagreement. It was agreed this recommendation will read: **“Provide technical assistance to health care organizations and professionals on the use of the tools of patient safety.”**

Recommendation #2e:

Adopt common terminology to be used in relation to patient safety and adverse event prevention.

Alternate language: (submitted by Dr. Utley)

Provide direction in the adaptation of a common patient safety terminology.

Director Lakin had asked if this was different from #1g. Dr. Laiben felt that #2e is was different, because #1g focuses on what healthcare organizations should do, while #2e is directed at the patient safety support center.

Dr. Utley noted that "adaptation" should have been "adoption". Dr. Laiben said he preferred Dr. Utley's alternative, with the change. There was no disagreement. It was agreed this recommendation will read: **“Provide direction in the adoption of a common patient safety terminology.”**

Recommendation #2f:

Share with the public patient safety data and disseminate consumer safety alerts.

William Schoenhard felt 'sharing patient safety data with the public' would be perceived by readers as meaning mandatory reporting. He asked if #2g didn't cover the concept of #2f, and if #2f could be deleted. Linda Bohrer noted that people inside MDI otherwise unfamiliar with the Commissions work had expressed a concern similar to Mr. Schoenhard's. Dr. Laiben confirmed that there

was no intent to imply mandatory reporting of adverse event data. His understanding was that #2f referred to the volume and quality data already available to the public.

Ken Vuylsteke felt #2f was very important from the point of view of empowering patients with information about their healthcare providers. However, he agreed that his understanding #2f was that the recommendation dealt with volume and quality data.

It was agreed that #2f was worth keeping, but that it needed to be redrafted to more clearly express the intent of the Commission. Dr. Laiben suggested a revised version to which everyone agreed. It was agreed the recommendation will read: **“Share patient safety information with the public and disseminate consumer safety alerts.”**

Recommendation #2g:

Collect, develop, and disseminate materials for healthcare consumers that help them make safer choices in their healthcare and course of treatment.

Alternate language: (submitted by Dr. Utley)

Collect, develop and disseminate materials to assist healthcare consumers regarding issues of patient safety.

Dr. Laiben stated he preferred the original statement, but with some changes. There was no disagreement. It was agreed the recommendation will read: **“Collect, develop and disseminate the materials to assist healthcare consumers in making safer healthcare choices.”**

Recommendation #2h:

Establish an “education coalition” to develop a multidisciplinary curriculum for undergraduate, graduate and continuing education of healthcare professionals on patient safety.

There were no comments or changes to this recommendation.

Recommendation #2i:

Conduct research to gain a better understanding of consumers’ views and beliefs about their safety as patients.

Alternate language: (submitted by Director Lakin)

Research consumers’ views and their opinions about their safety as patients.

Alternate language: (submitted by Dr. Utley)

Conduct research into the patient safety related views and beliefs of consumers.

Dr. Laiben preferred Director Lakin’s alternative. Dr. Utley was not entirely happy with the phrase “their safety as patients”. Ken Vuylsteke suggested another alternative, to which everyone agreed. It was agreed this recommendation will read: **“Research consumer views, and their opinions about patient safety.”**

Recommendations #2j:

Provide a setting for Missouri citizens, who are leaders in the area of patient safety, to work together to advance patient safety activities.

and 2k:

Establish a process for healthcare organizations and professionals to report adverse events and outcomes,) “near misses” and their solutions to patient safety problems.

There were no comments or changes to these recommendations.

Recommendation #2l:

Analyze data and make findings available on areas likely to compromise patient safety.

Alternate language: (submitted by Director Lakin)

Analyze data and make findings available.

Alternate language: (submitted by Dr. Utley)

Analyze patient safety data and make findings available.

Dr. Laiben stated he preferred Director Lakin’s alternative. There was no disagreement. It was agreed the recommendation would read: **“Analyze data and make findings available.”**

Recommendations #2m:

Work with the federal and state governments, regulatory agencies, JCAHO, and other organizations involved with patient safety reporting to eliminate duplication of activities.

and #2n:

Report periodically to the General Assembly on patient safety issues and educate new members on patient safety issues.

There were no comments or changes to these recommendations.

Recommendations #3a:

Create protections for information shared among healthcare organizations and professionals that are designed solely for improving patient safety and healthcare delivery processes and systems.

#3b:

Expand the definition of “peer review committee” in the current peer review statute to include non-healthcare providers, employees and additional healthcare professionals.

#3c:

Recommend ways to eliminate cumbersome requirements for appointing healthcare organization and professional peer review committees.

#3d:

Protect patient safety data, documents or information reported to the “Patient Safety Support Center” for improving the quality of healthcare from use in civil, judicial or administrative procedures.

and #3e:

Identify disincentives for reporting adverse events and recommend changes as appropriate in the best interest of patients.

Director Lakin had asked if #3a and #3d were redundant. Dr. Laiben stated he didn't think so. The commissioners agreed.

There were no other comments or changes to these recommendations.

Recommendation #3f:

Establish protections preventing adverse employment actions against healthcare professionals or employees who report unsafe healthcare conditions or adverse events.

Alternate language: (submitted by Director Lakin)

Prevent adverse employment actions against healthcare professionals or employees who report unsafe healthcare conditions or adverse events.

Alternative language (submitted by Dr. Smith):

Promulgate legislation to prohibit any healthcare organization in Missouri from taking adverse employment or credentialing action against an individual healthcare professional based on that individual's participation in the development, collection, reporting or storage of patient safety data.

Dr. Smith stated he actually preferred Director Lakin's alternative. No one disagreed. It was agreed this recommendation will read: **"Prevent adverse employment actions against healthcare professionals or employees who report unsafe healthcare conditions or adverse events."**

Recommendations #4a:

Work with accreditation agencies responsible for establishing healthcare professionals' education requirements to strengthen their educational curriculum with key patient safety concepts.

Alternate language: (submitted by Dr. Utley)

Work with accreditation agencies responsible for establishing healthcare professionals' education requirements to incorporate key patient safety concepts into educational curricula.

#4b:

Promote ways to improve communication among healthcare professionals and organizations at all levels of healthcare delivery.

Alternate language: (submitted by Dr. Utley)

Promote improved communication among healthcare professionals at all levels of healthcare delivery.

and #4c:

Assure competency of healthcare professionals in patient safety through continuing education activities.

Alternate language: (submitted by Dr. Utley)

Promote patient safety competency of healthcare professionals through continuing education activities.

Dr. Laiben preferred Dr. Utley's suggestions for all three of these sub-recommendations. No one disagreed. It was agreed they will read:

#4a:

“Work with accreditation agencies responsible for establishing healthcare professionals’ education requirements to incorporate key patient safety concepts into educational curricula.”

#4b:

“Promote improved communication among healthcare professionals at all levels of healthcare delivery.”

#4c:

“Assure competency of healthcare professionals in patient safety through continuing education activities.”

Recommendation #5a:

Healthcare professional and organization licensing bodies should work with certifying and credentialing organizations to develop more effective methods to identify unsafe healthcare professionals and organizations and take action.

Dr. Utley had asked what #5a means. Dr. Laiben stated he had the same question. Kathryn Nelson stated that this recommendation comes directly from the Institute of Medicine report, and that the details would be expressed in the background text. The Commissioners were comfortable with keeping this recommendation.

Subsequent discussion lead to the decision to add a recommendation #5b, dealing specifically with licensure for currently unlicensed healthcare facilities. Dr. Laiben asked Lois Kollmeyer to draft a #5b by Monday, June 7.

Recommendation #6a:

Consumers, healthcare professionals and organizations should support efforts to make patient safety education materials available to all Missourians.

There were no comments or changes to this recommendation.

Recommendation #6b:

Consumers, healthcare professionals and organizations should encourage the development of useful and innovative patient education materials.

Alternate language: (submitted by Dr. Smith)

The Patient Safety Center should develop patient education materials and make them available to all Missourians directly and through healthcare organizations.

Dr. Laiben stated he liked Dr. Smith's changes, however he felt the thought expressed by Dr. Smith had been covered with the sub-recommendations under #2, specifically #2g. Dr. Laiben suggested an alternative. Dr. Utley and several

others suggested small modifications. It was agreed the recommendation will read: **“Consumers, healthcare professionals and organizations should encourage the development and use of innovative patient education materials.”**

Recommendation #6c:

The patient should have access to information and materials to educate them on health conditions, treatment options and navigating the healthcare system.

Alternate language: (submitted by Dr. Utley)

Ensure patient access to information and materials to educate them on health conditions, treatment options and navigating the healthcare system.

Dr. Laiben agreed with Dr. Utley's language, but with a few changes. There was no disagreement. It was agreed this recommendation will read: **“Ensure patient access to educational information and materials on health conditions and treatment options.”**

Recommendation #6d:

Education of both consumers and healthcare professionals and organizations will target enhanced communication and support the patient's central role in the healthcare team.

Alternate language: (submitted by Dr. Smith)

Educate patients, healthcare professionals and healthcare organizations to enhance communication and support the patient's central role in the healthcare team.

Dr. Laiben said he preferred Dr. Smith's suggestion to the original. There was no disagreement. It was agreed the recommendation will read: **“Educate patients, healthcare professionals and healthcare organizations to enhance communication and support the patient's central role in the healthcare team.”**

Recommendation #6e:

The patient should have access to the patient advocate and their role in the healthcare organizations with which they do business.

Alternate language: (submitted by Dr. Utley)

Ensure patient access to a designated patient advocate.

Dr. Laiben stated he preferred Dr. Utley's language. There was no disagreement. It was agreed this recommendation will read: **“Ensure patient access to a designated patient advocate.”**

Recommendation #6f:

State government should maintain consumer healthcare advocacy and healthcare complaint investigation systems in state agencies and organizations and continue the state's active response to consumer concerns.

Lois Kollmeyer reported that the Missouri Hospital Association desired more than maintenance of current state agency complaint investigations. MHA would like to see an expansion of state complaint investigations to entities not currently licensed. Linda Bohrer noted that expanded state agency oversight would be discussed in recommendation #5. Kathryn Nelson concurred. Expanded complaint investigation activity had to be based on new licensure requirements. However, an additional sub-recommendation under #5 would be needed to address this. Dr. Laiben asked Lois Kollmeyer to draft a #5b in response to MHA's concerns.

Dr. Laiben suggested shortening this recommendation. There was no disagreement. It was agreed this recommendation will read: **“Maintain consumer healthcare advocacy and healthcare complaint investigation systems in state agencies and organizations, and continue an active response to consumer concerns.”**

Recommendation #7a:

Healthcare organizations and professionals as well as their professional healthcare associations should work with insurers, including the new Missouri Medical Malpractice Joint Underwriting Association board of directors, to provide medical liability discounts for healthcare professionals and organizations participating in patient safety activities.

Dr. Laiben suggested shortening this one. There was no disagreement. It was agreed this recommendation will read: **“Insurers, including the new Medical Malpractice Joint Underwriting Association board of directors, should provide medical liability discounts for healthcare professionals and organizations participating in patient safety activities.”**

Recommendation #7b:

Payers and responsible parties should include contracting provisions that contain patient safety incentives in any contract they enter into that results in payment for healthcare services.

Alternate language: (submitted by Dr. Smith)

Payers and responsible parties should include contracting incentives to foster patient safety initiatives in any contract resulting in payment for healthcare services.

Dr. Laiben stated he preferred Dr. Smith's suggestion. Dr. Utley was not comfortable with the reference to "any contract", and offered an alternative version. Linda Bohrer suggested dropping the word "any", and Dr. Utley was satisfied with that. There was no disagreement. It was agreed the recommendation will read: **“Payers and responsible parties should include contracting incentives to foster patient safety initiatives in contracts for healthcare services.”**

II. Closing comments

Dr. Laiben asked Lois Kollmeyer to email her #5b to him to review and send out to the group, and vote on it by email.

Linda Bohrer reviewed the schedule for completing the report:

- Next week, recommendations will be assigned out to staff to put together the background text for each.
- On June 10th, the Executive Summary will be emailed to all Commissioners.
- Comments and edits for the Executive Summary must be in to Linda Bohrer by June 14th.
- On June 16th, all the background text assigned to various MDI staff will be turned over to Randy McConnell to edit and unify the text.
- There will be a teleconference on June 17th, as previously scheduled, to discuss the Executive Summary.
- On June 24th, the entire report will be sent to the Commissioners.
- On June 28th at 8 AM, all comments and edits need to be in to Linda Bohrer. Comments about major ideas that are missing or incorrectly stated will be accepted. However, Linda does not plan on looking at any comments related to minor edits and semantics.
- MDI staff will complete work on the report by July 2nd, and copies will be sent to all the Commissioners before July 7th.

Dr. Spoon asked for the status of the signature page. Linda Bohrer responded that an email will be sent on Monday to those who have not yet signed the signature page. Anyone who will not be able to sign on July 7 needs to respond so that the signature pages can be FedExed.

The conference call was concluded at 2:30 PM.